

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

May 28, 2019

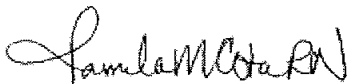
Ms. Amy Tatro, Manager
Pennington House
1822 North Ave
Burlington, VT 05408-1303

Dear Ms. Tatro:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 23, 2019**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief



MAY 17 2019

PRINTED: 05/03/2019
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0607	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/23/2019
NAME OF PROVIDER OR SUPPLIER PENNINGTON HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1822 NORTH AVE BURLINGTON, VT 05408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
R100	Initial Comments:		R100		
	An unannounced onsite investigation of a complaint was conducted by the Division of Licensing & Protection on 4/23/2019. The following regulatory deficiencies were identified during the investigation.				
R146 SS=D	V. RESIDENT CARE AND HOME SERVICES		R146		
	5.9.c (3)				
	Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate;				
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that they provided instruction and supervision to all direct care personnel regarding resident health care needs. Findings include:				
	Per record review The care plan, dated 1/7/19, states that Resident #1 is now a two person transfer for all transfers. Resident #1 experienced a fall on 2/25/2019 during a transfer from his wheelchair to his chair after lunch. The incident report states that a staff member attempted to transfer Resident #1 alone his/her Left Knee gave out. The resident fell landing on top of the staff member attempting to ease the resident to the floor during that process. The staffing that day included 1 regular staff and 3 fill in staff from another home. The staff member who transferred the resident was a substitute who was working for the first time in this home according to the regular staff member who was present. The former				

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

321911

If continuation sheet 1 of 4

R146 - R178 POC accepted 5/28/19 mHigginson/PM

Division of Licensing and Protection

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R146	Continued From page 1 Manager was also working that day. The Manager was the person who did the scheduling for the home. The Mobility Care Plan states that the resident is a 2 person transfer. It states that in 2018 s/he had 2 falls which resulted in a new protocol to have a 2 person transfer. The regular staff member who was on duty stated s/he was administering medications when s/he heard a noise and ran to see what had happened. The regular staff person stated that it was at that time s/he told the substitute caregiver that the resident was a 2 person transfer. The Interim Manager in an interview on 4/23/19 at 12:55 PM stated that the caregiver works at another group home. Staffing for each home is done by the House Manager to assure that the manager is aware of any new staff coming into the facility. The the process is that the staff who is acting as a substitute should have 2 shifts of shadowing regular staff and then they are assigned to do fill in shifts. During the first shifts the manager and the regular staff should be giving the substitute information regarding the special needs of the residents and the substitute should be told to review the care plans for each resident.		R146		
R178 SS=D	V. RESIDENT CARE AND HOME SERVICES		R178		
	5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt,				

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R178	<p>Continued From page 2</p> <p>appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to assure that there was a sufficient number of qualified personnel to maintain a safe and environment. A staff member would be qualified if they are aware of the resident's history, needs and the proper care planned way to meet those needs. Findings Include:</p> <p>Per record review, the care plan, dated 1/7/19, states that Resident #1 is now a two person transfer for all transfers. Resident #1 experienced a fall on 2/25/2019 during a transfer from his wheelchair to his chair after lunch. The incident report states that a staff member attempted to transfer Resident #1 alone his/her Left Knee gave out. The resident fell landing on top of the staff member attempting to ease the resident to the floor during that process. The staffing that day included 1 regular staff and 3 fill in staff from another home. The staff member who transferred the resident was a substitute who was working for the first time in this home according to the regular staff member who was present. The former Manager was also working that day. The Manager was the person who did the scheduling for the home.</p> <p>The Mobility Care Plan states that the resident is a 2 person transfer. It states that in 2018 he had 2 falls which resulted in a new protocol to have a 2 person transfer. The regular staff member who was on duty stated s/he was administering medications when s/he heard a noise and ran to see what had happened. The regular staff person stated that it was at that time s/he told the substitute caregiver that the resident was a 2</p>		R178		

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R178	Continued From page 3 person transfer. The Interim Manager in an interview on 4/23/19 at 12:55 PM stated that the caregiver works at another group home. Staffing for each home is done by the House Manager to assure that the manager is aware of any new staff coming into the facility. The the process is that the staff who is acting as a substitute should have 2 shifts of shadowing regular staff and then they are assigned to do fill in shifts. During the first shifts the manager and the regular staff should be giving the substitute information regarding the special needs of the residents and the substitute should be told to review the care plans for each resident.		R178		

Pamela M. Cota, RN
Licensing Chief
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2306

May 13, 2019

Dear Ms. Cota:

Listed below are the plans of correction for each deficiency cited in the unannounced on site anonymous complaint investigation at Pennington Group Home, 1822 North Avenue RCH of Howard Center Developmental Services that took place on April 23, 2019.

R146 V. Resident Care and Home Services

5.9.c. Plan of Care

1. The Team Lead, Amy Tatro, on May 8, 2019 reviewed with all Pennington direct care personnel, the process when a "fill in staff" comes to Pennington to help with coverage. To ensure that deficient practices do not recur the Residential Manager will review the Residential Plan of Care's with all direct care personnel, including "fill in staff," prior to them supporting any of the clients. Along with this, the Residential Manager will make sure that when scheduling shifts, that there will be no more than one "fill in staff" at a time with Pennington direct care personnel. The Team Lead also created a checklist for all "fill in staff" to review prior to supporting clients; this is to ensure they have read all the appropriate documentation. Corrective action is complete.

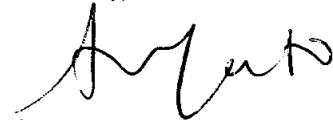
R178 V. Resident Care and Home Services

5.11. Staff Services

1. To ensure that deficient practices do not recur the Residential Manager will make sure that when scheduling shifts, that there will be no more than one "fill in staff" at a time with Pennington direct care personnel and that all "fill in staff" have read the appropriate documentation. Corrective action is complete.

Please feel free to contact me with any questions or comments.

Sincerely,



Amy Tatro
Team Lead, Pennington
Howard Center
102 South Winooski Ave
Burlington, VT 05401
(802) 488-6515

atatro@howardcenter.org